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# Interpersonal Influences in the Scale-up of Male Circumcision Services in a Traditionally Non-circumcising Community in Rural Western Kenya

**Alfredo F.X.O. Obure,** MPhil, PhD, is a behavioral research scientist at Great Lakes University of Kisumu in Kisumu, Kenya.

**Erick O. Nyambedha,** MA, PhD is a medical anthropologist and Head of Department of Sociology and Anthropology at Maseno University in Kisumu, Kenya.

**Boniface O. Oindo,** MSc, PhD, is Senior Lecturer at School of Environment and Earth Sciences (SEES), and Chairman of SEES Graduate Studies at Maseno University, in Kisumu, Kenya.

Authors' Note: Please address correspondence to Dr. Alfredo F.X.O. Obure, Great Lakes University of Kisumu, P.O. Box 2224, Kisumu, Kenya: e-mail: afxobure@gmail.com

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Alfredo F.X.O. Obure
Great Lakes University of Kisumu, Kisumu, Kenya

Erick O. Nyambedha
Department of Sociology and Anthropology, Maseno University, Kisumu, Kenya

Boniface O. Oindo
School of Environment and Earth Sciences, Maseno University, Kisumu, Kenya

**Abstract**

Promoting male circumcision (MC) is now recognized as an additional, important strategy for the prevention of heterosexually acquired HIV infection in men, and plans are underway to scale-up this intervention especially in non-circumcising communities, with generalized HIV pandemic. This qualitative study identifies and characterizes the role of social and interpersonal factors in the scale-up of MC services in a rural non-circumcising community in western Kenya. Twenty-four sex-specific focus group discussions were conducted with a purposive sample of Luo men and women (15-34 years). Peer and youth groups, girlfriends and women, parents, and cultural political, religious, school leaders were identified as key influences in the scale-up of MC services. The study concludes that social and interpersonal forces create opportunities and constraints for scaling up the MC intervention. Planners of MC projects should therefore harness the power of informal networks and social structures to enhance community engagement, motivate behaviour change and increase demand for MC services.

## Introduction

HIV/AIDS remains a critical challenge to socio-economic development of many countries in sub-Saharan Africa (SSA). As more people access the life-saving HIV care and treatment, more HIV infected people survive longer, leading to a slight increase in HIV prevalence, and many more new infections may occur for every additional person started on such treatment (Joint United Nations Programme on HIV/AIDS [UNAIDS], 2006; Kenya AIDS Indicator Survey [KAIS, 2007). Integration of evidence-based HIV preventive measures is the only realistic hope for stemming the HIV pandemic (Bailey, et al., 2007; Morris, 2007). Promotion of condom use, reduction in sexual partners, and treatment for other sexually transmitted infections (STI) are some of the main intervention strategies that have been employed by national AIDS control programs.

Based on the results of three randomized control trials (Auvert et al, 2005; Bailey et al., 2007; Gray et al., 2007) and other accumulated evidence showing that male circumcision (MC) reduces the risk of HIV acquisition, the World Health Organization (WHO) and UNAIDS (2007) concluded that the efficacy of MC in reducing female to male HIV transmission is now proven beyond reasonable doubt, and recommended that MC should be considered as part of a comprehensive HIV prevention package. MC is the surgical removal of the foreskin of the penis and is one of the oldest and most common surgical procedures worldwide, undertaken for religious, cultural, social, and medical reasons. Approximately 30% of adult men worldwide are circumcised. In SSA, about two-thirds of men are circumcised (UNAIDS & WHO, 2007). Many SSA countries are scaling medicalized MC services to bring more quality benefits of MC to more people over a wider geographical area more quickly, more equitably, and more lastingly.

The need for scaling MC interventions in Kenya is more urgent in Nyanza province of western Kenya than any other region of the country. Although Kenya's overall HIV prevalence is estimated at 7.8%, Nyanza province leads other regions with a 15.3% HIV prevalence (KAIS, 2007). The region is mostly inhabited by the Luo, one of the largest ethnic groups in the country; there are around 40 indigenous ethnic groups in Kenya. Compared to other major ethnic

groups, HIV prevalence is highest among the Luo at 21% (Kenya Demographic Health Survey [KDHS], 2003). Unlike majority of other ethnic groups in Kenya, the Luo do not traditionally circumcise their males; approximately 90% of Luo men are uncircumcised (Agot, Ndinya-Achola, Kreiss, & Weiss, 2004). Recent studies in Kenya show that non-circumcised males have higher risk of HIV infection compared to circumcised males (Agot et al., 2004; KAIS, 2007; KDHS, 2003). KAIS (2007) reported that 13% of men who were uncircumcised were HIV infected, compared with three percent of those who were circumcised. Its high HIV prevalence, combined with its low MC prevalence make Luo inhabited communities appropriate for scaling MC intervention.

However, there are a wide range of behavioral, socio-cultural, political, economic, and project design issues to consider in the context of scaling MC intervention, especially in traditionally non-circumcising communities (McLeroy *et al.*, 1988; Muula, 2007; Simmons & Shiffman, 2007). There is need to identify how interpersonal contact, informal communication, and social networks and channels of diffusion shape, can be harnessed to achieve faster and socially acceptable adoption (Diaz & Cabral, 2007; Glanz et al., 2002; Rollnick et al., 2002). Although several previous studies have been conducted on acceptability of MC in traditionally non-circumcising communities in SSA (Westercamp & Bailey, 2007), most of these studies were done before MC was conclusively recommended as an additional HIV preventive strategy. In the context of scaling up MC intervention, there is need to understand how social forces shape both the demand for and supply of MC services. The purpose of this study was to identify and characterize how interpersonal factors may affect the decisions of males being offered MC in a rural non-circumcising community in western Kenya, with high HIV prevalence.

## Methods

This study was a descriptive qualitative inquiry that focused on perceptions of youths and young adults of social factors that could shape both the demand for and supply of MC services in their community. This study was conducted in 6 randomly selected villages of Nyando division, an impoverished area in rural western Kenya. Research activities were conducted during February and April of 2008. The research ethics committee of Maseno University, Kenya approved this study. Before data collection, questions regarding procedures were addressed and participants provided written informed consent.

### Participants

Purposeful sampling was used to recruit participants who were typically out-of-school male and female youths and young adults, ranging in age from 15 to 34 years. Those in this age bracket are a sexually active high risk group for HIV infection, and males in this age set are target for projects promoting MC in Kenya (GOK, 2008). Purposeful sampling enabled the researcher to seek out individuals who were able to help answer the research questions (Ritchie & Lewis, 2003). Participants were recruited through local village elders and from established youth groups in the community.

### Data Collection and Analysis

Focus Group Discussions (FGDs) were used for data collection (Bader & Rossi, 1998). An FGD guide was developed and was comprised of a set of open-ended questions that covered three topical areas: knowledge and beliefs regarding MC; how adoption of MC can be enhanced in the community, and groups or individuals who had the greatest influence in community decision-making. The guide was translated from English into Luo and back-translated. All discussions with males were moderated by the first author; a native female moderator, a sociologist trained in qualitative research methodology, led all discussions with females. Two same-sex research assistants took detailed notes during male and female FGDs. Participants were given a choice of participating in the indigenous language, *DhoLuo*, or in *Kiswahili*, or in English. Debriefing sessions were held with research assistants to identify emerging issues and memos were written for further exploration in subsequent FGDs. A total of 24 FGDs were conducted; each session included 6 to 12 participants.

Proceedings of each FGD were transcribed immediately after each session and later translated into English. FGD narratives were imported into the Atlas.ti (version 5.0), software (Scientific Software Development, 2004) for analysis. The first author reviewed, coded, and analyzed all data. Through content analysis, transcripts were first coded for concepts, dominant themes, and variability (Charmaz, 2006; Ritchie & Lewis, 2003). This initial analysis was segmented by target population (male or female FGDs); then compared across the target

populations. Quotations relevant to each of the categories were identified from the transcripts for qualitative reporting.

To establish rigor and manage threats to trustworthiness (Ritchie & Lewis, 2003), reflexivity and auditing were employed during the initial analysis. Peer reviewing and member checks were used to enhance validity of the data (Bowen, 2005; Ritchie & Lewis, 2003). In peer reviewing, the second author, who has expertise in qualitative methods, examined the FGD transcripts, coding sheets (which identified concepts, categories, and themes), and the summary of the findings (Bowen, 2005). The peer review identified the analysis as being completed in a logical and systematic manner and the findings were reasonable and accurate based on field data. Member checks were conducted by telephoning some of the FGD participants and checking with them the accuracy of our result summaries and observations (Ritchie & Lewis, 2003). Crosschecking with these participants helped the researcher to maintain reflexivity by encouraging self-awareness and self-correction. This process allowed for participant validation of the findings (Bowen, 2005).

## Results

There were 126 males and 107 females who participated in 24 FGDs in the study. The majority had six or more years of education, and worked in petty trade/small business, farming, or reported that they were unemployed. The results for this study are organized according to six main categories that emerged from data analysis. For each theme, several categories that emerged during data analysis are presented, supported by relevant quotations. Interpersonal influences in male decision making regarding MC included peers and youth groups, women and girlfriends, parents, community elders and political leaders, church leaders, and the school system, which includes teachers.

### Peer influence

Discussants described several positive aspects of peer influence in circumcision preference. Most of the male discussants spoke positively about the kinds of influence their peers had and how youth group and peer norms could encourage them to seek circumcision. One discussant, who disclosed that he had an appointment to circumcise at the sub-district hospital that day, had this to say:

> Fellow youth role models are best placed to mirror the successes of MC to fellow peers. At the moment I have about 10 of my peers waiting for me to get circumcised. They are all waiting for the outcome of my procedure. I am going to be their role model. They are all saying that if I am successful, then they will follow me. They are all putting a "lets wait and see" attitude. I know once mine is done, they will all want to go for it (Male, 27 years old).

Males in the community, who have already circumcised, were identified as source of influence, and as role models, who could motivate more youth to circumcise. Discussants expressed that using already circumcised youth from the community was one way of demystifying MC and disputing negative community beliefs about MC. One discussant observed:

> There is this saying that "set a thief to catch a thief". Youth can influence themselves… the youth who have been circumcised should be involved to tell us about the benefits of MC and their experiences… or what they have gotten… some of these people like politician may be forcing you with something he himself hasn't done…and is not even thinking about doing (Male, 23 years old).

Another male discussant observed:

> If MC is targeting the youth, then let the projects involve the youth. I have seen many cases in this community when youth agendas are hijacked and championed by very old people…and they eat all the money. I think it is a youth issue and we should be involved. We have seen projects here failing because they are run by foreigners or people we cannot identify with. Even MC, I think there are youth practitioners who can do this thing [*provide MC services*]. The youth must be the solution of their problem… that age gap is a barrier [*MC promoted by older people*]. For it to succeed well, the youth must be involved. There are many youth networks and groups in this community (Male, 32 years old).

Most of the discussants were aware of existing youth groups to which they identified. They observed that these youths must be actively involved in the promotion of MC services in the community. One female discussant observed:

> I also think that these MC projects must actively involve local youth groups. These groups can organize for some educational sharing sessions that are quite convincing… because it is

> interactive…or even similar seminars. In such groups males who have circumcised can share or even show others how a circumcised penis looks like live… Just knowing that one of us is circumcised will be a big source of influence… We will then realize that circumcision is thus not such a big deal…it can happen, it can work…it is not something so far from us… it makes it real… For now, circumcision is still just something talked about…but you know there must be a reason to push you to even think of circumcising (Female, 21 years old).

**Influence of female sexual partners**

The role of female sexual partners in motivating for circumcision of males in the community also featured prominently in most of the discussions. There were three main common arguments from both male and female FGDs in support of women's involvement. Firstly, the empowerment of women in sexual decision-making process was singled as one of the pillars to the success of condom use for HIV prevention. Some discussants observed how they have been denied sex at the "heat of the moment' because their female partners insisted that condoms had to be used. The following quotations illustrate discussions on the role of women in condom promotions and how they can also influence MC uptake:

> My friend, if the lady insists that you use a condom … and you are already prepared for sexual intercourse…you may curse not having one in your pockets. It happened to me... These days, I always arm myself with one…just in case. Women are good at having what they want at that sexual moment (Male, 24 years old).

> You know like with condoms, if a woman says no condom no sex, then men would look for it anywhere… so if they insist on circumcision, then it could work... mothers would socialize girls to prefer circumcised men… so the girl would not want me if am not circumcised… she first asks if I am sharpened [circumcised]… that is the first qualification for sex (Male, 24 years old).

> The success of condoms for HIV prevention was on the strength of women. Women should begin to insist on having sex with circumcised men. You will see men flocking the health facilities because of the influence of women (Female, 31 years old).

There were several suggestions from female discussants on how to engage male partners in dialogue to motivate them to seek MC services. The most common suggestion among the discussants was a soft persuasive dialogue with male partners and not pressuring them into seeking MC. One of the discussants expressed:

> To women, men are very easy to deal with… I think we can influence the men even more than their fellow men… you just wait until you are relaxed on the pillow, then you just feed him slowly with words… you don't scare him or make him feel that he is not satisfying you… or that he is not man enough… you just have him thinking about it over some time… don't rush him, men will get scared and feel that the woman is now trying to take charge and dictate him (Female, 29 years old).

Secondly, discussants concurred that women in their community have been worst hit by the HIV pandemic and should thus play a central role in its preventive efforts. Both male and female discussants acknowledged that women were more vulnerable to HIV infection because of their status in society compared to men and because of the social construction of sexual decisions. It emerged that most women in relationships have less say about when and how they want to have sex, and are not always able to negotiate for monogamy or secure sex practices. Female discussants observed that their male counterparts were culturally permitted to have multiple partners and put them at greater risk for HIV. These factors were seen to impact on the actual role of women in HIV prevention. One of the discussants expressed:

> Our men are allowed to marry more than one wife…our culture allows them to have multiple partners. Those with more are heroes. But we [women] patiently remain faithful, waiting for them to get HIV elsewhere and as we welcome them back, we receive HIV. You know we are culturally obligated to just give it the man …I mean sex…If MC has been found to prevent them, we want to be involved in speaking to our men to protect u by getting circumcised. If he refuses to use condom…they often do, then there is also the circumcision that can make him not get HIV outside (Female, 32 years old).

There was consensus among female discussants that if MC has a HIV preventive effect to men, it would equally be protective to them. One of the female discussants observed:

> I also think that if my partner is circumcised, then my chance of getting HIV is lower when I

> sleep with him. If I add this to the use of condoms, then I think I have double protection against AIDS. This is because they do not use condoms consistently and if you insist on it, then he accuses you of not trusting him (Female, 21 years old).

However, few male discussants were opposed to involving women in promotion of MC services. Their main concern was that it would lead to stigmatization of males who do not circumcise. One discussant had this to say:

> Women will begin to isolate men who do not circumcise… and if the couple gets HIV, an accusation finger will be pointed to the man because he is not circumcised" (Male, 32 years old).

Some female discussants observed that they would face major challenge or even domestic violence were they to suggest MC to their male partners because it was not culturally appropriate for women to suggest sexual options. One discussant expressed:

> He may perceive you are a prostitute…that you have been unfaithful to him and was experimenting with other men outside… let me tell you…even if you were to ask him to try another sex style, he may ask you where you leaned it from…this makes us passive players in sex…most women have sex to satisfy the man. Most of us do not enjoy sex really… the more the man gets his rounds, the more he is satisfied… he does not consider you…so imagine you were to come home and start telling him about the need to get his penis cut… He can give you a hot slap… it is like you have been sexing another man (Female, 29 years old).

**Parental influences**

Results of qualitative analysis indicated that parents played a key role in planning and implementing MC projects in the Nyando community, especially by motivating and supporting circumcision of male children and adolescents. Discussants observed that perceived support or endorsement for MC from male household heads or fathers would be useful to enhance uptake of the service among youth. There were several justifications for this argument. First, most male youth mentioned that they look up to their fathers as role models and would be inclined to circumcise if the male parent suggested it. One discussant observed: '*I would certainly do it if my father asked me to. I respect his decisions… they [*decisions*] are meant to protect me*" (Male, 18 years old).

Secondly, male discussants observed that moral support and encouragement from their fathers during healing process would be vital to reassure them of having made the correct decision. Some observed that on sexual and reproductive matters, they would rely on the support of their fathers so that they don't feel guilty of making a wrong decision. One of them had this to say:

> You know when your old man [*father*] supports you, then you also go for it head-high [*motivated, with confidence*], and you know that you have made the right decision. If things get worse [*adverse effects, complications*] then you know he will still encourage and support you. Just like I would talk to him when I have an STI… I know he will be mad and I will get a long lecture, but he is a man, he will understand that these things happen (Male, 23 years old).

Thirdly, it emerged from qualitative analysis of FGD data that fathers were considered a major influence in household decision-making process and because of these power dynamics, their support for MC would enhance it uptake among their sons. Discussants mentioned that male household heads influenced almost all economic decisions in the household, including distribution of household labour, and determining how household resources are expended. One of the discussants said:

> For example, our parents should be part of those supporting us in the process, including financial charges that we may not know until after circumcising. Again fathers are culturally the main decision makers for households. They can really champion this thing. If your father decides that you are to get circumcised, then it will be done. They are the centers of power in the family … you cannot neglect the father… [*They*] should be targeted first, as men and as deciders in their families (Male, 21 years old).

The role of mothers was particularly evident in neonatal/infant circumcision. Discussants mentioned that one of the roles of mothers was to care for the health of their children. They were expected to "*feed them, care from them, and protect them from diseases"* (Male discussant, 34 years old). For example, it was expected of mothers to remember vaccination dates of their children and ensure they are taken for vaccinations to prevent diseases. A discussant said:

> In the same way that mothers made decisions about healthcare needs of their infants, they could also have a major role in making decisions

> of whether or not to circumcise their sons (Female, 28 years old).

One discussant, single mother, described this perception as follows:

> In fact I have encouraged my boyfriend to go for it. I am even thinking of taking my [*3 year old*] son for circumcision (Female, 23 years old).

On the need for parents to be involved in circumcision decision making, one male discussant had the following to say:

> I think we should also involve parents, especially mothers…let them decide and circumcise infants or pre-school kids…so that they grow up already circumcised and semi-protected…you know since this is not our culture, it can work best if parents decide for us just as they do to protect us when we are young and school us to secure our future…what is that future if you may die because of sexual reasons that can be avoided just by a cut that heals in a matter of days (Male, 22 years old).

Specifically, the involvement of mothers in deciding whether or not to circumcise their infant sons was emphasized in many of the discussions. One discussant observed:

> When still at the health centre, the mother is counseled and allowed to make decision that will protect the child in future. Mothers must protect their children. It is their duty. Why wait for the boy to make the decision himself yet this thing is helpful? You know, convincing an adult is very difficult... if the penis is left to grow bigger, the adult male will begin to fear pain because they have learned that circumcision is very painful… the rumours will discourage him. It should be included in the maternal and child health prenatal counseling package… so that mothers can decide (Male, 31 years old).

**Influence of community elders and political leaders**

Discussants in all FGDs stressed the need to identify local sources of social influence that can effectively facilitate community involvement in planning and implementation of MC projects and ensure cooperation from influential members and make use of them without reinforcing harmful power dynamics or hierarchies. Village elders, chiefs, politicians, religious leaders and school teachers were frequently mentioned as opinion influencers, who could facilitate community acceptability and uptake of MC services. Some discussants observed that the endorsement of community opinion leaders was important if projects promoting it would have favorable cultural environment to promote it. A discussant observed:

> You know, the Luo are a structured community; we have our elders and leaders, who are like the cultural watchmen. This circumcisions touches on our culture and there is need to talk to the Luo Council of Elders so that they give it a green light. If they oppose it, projects promoting it will have it very difficult even to talk at a baraza [*local community meeting*]. There is need to begin with and get the blessings of elders. Our major politicians should also be talked to so that they support or simply speak something positive about circumcising males (Male, 31 years old).

Another discussant observed:

> We should have our elders involved in this… just like the Luo council of elders… if they are made to be part of this thing, then we will start seeing it as normal… but if they continue criticizing male circumcision for cultural and political reasons, then these projects cannot go anywhere. The elders can be a very big barrier. We need to involve them (Male, 32 years old).

There was however no consensus from the group discussions that the community elders had to endorse MC for it to be considered a public health intervention. Some discussants were emphatic the decision to circumcise was an individual's personal decision and did not need any endorsement from Luo elders. One of the discussants expressed:

> It is fine to tell elders about health benefits of circumcision. They can talk to males in their communities to consider circumcising. But I think circumcision is an individual's decision…elders must not decide for me about it…Did elders sit and endorse that Luos stop the initiation rite of removing their lower teeth? Elders cannot decide for me about something that is useful to me personally, and which affects my own body. Non-circumcision does not have any cultural significance among the Luo. Why should we rely on elders' decisions or community direction about it? Circumcision is being introduced for health reasons and not as a cultural practice (Male, 34 years old).

On the role of local politicians, one respondent had the following to say:

> Let us see them [*politicians*] supporting this thing [MC scale-up] fully as a special

> intervention …even through being involved in organizing mobile MC services… Most of these politicians, like our MPs [*parliamentarians*], have a way around with unemployed youth… Most of the time when they are in the village, youth flock their homes waiting for '*gonywa'* [*hand-outs*] at the end of the day. It is here [*these occasions*] that they can also convince us and even support us [*financial support during healing*] to do it… If he tells the youth about the value of this thing [MC] then it could work magic… (Male, 20 years old).

Discussants expressed that local leaders play a persuasive role in influencing circumcision-seeking behaviour among males in their communities. The multiple implications of their influence - positive and negative - need to be considered when designing MC interventions.

**Influence of religious leaders**

The role of religious leaders and structures was also emphasized in most FGDs. Discussants expressed that many people look up to their religious leaders for direction and many young males would most likely trust them. One discussant expressed this perception as follows:

> The pastors in churches should talk about this thing *[MC intervention*]. Pastors are always considered right... what they say is good and coming from a messenger of God (Female, 19 years old).

There was also a suggestion from discussants that churches provided a key forum on which the youth and young adults could be reached.

> Must youths go to church, almost all, only very few of us don't... In church, this thing [*MC intervention*] can be discussed… Religious leaders have a big audience every week, and even those who seek advice from them. They can even set up youth conventions to discuss MC and why it is important…it can help a lot. They can mobilize and influence us [Male, 22 years old).

Another discussant, who introduced himself as a religious leader, said:

> Our church [the Catholic] has been opposed to condom use. Circumcision is in the bible and Jesus himself was circumcised. The church should take a central role in teaching the youth about the benefits of MC. We must be involved as church leaders in HIV prevention efforts… it is our moral duty to protect our people… but this does not mean we promote sex out of wedlock. Abstinence and faithfulness among married partners still remain key messages of the church. MC only comes in because the youth have a hot blood [*sexually active*] and cannot be predicted…anything can happen when a young man meets a woman and their blood get hot. Reason will jump through the window…this is where MC can help (Male, 33 years old).

Some participants indicated that their churches have HIV prevention seminars and workshops for their youth, and even older members of the church, and could be a key channel of advocacy. One of the discussants said:

> In our church, every last Sunday of the month, the youth meet after church services to discuss issues relating to sexual health. Our pastor attends some of these sessions… I think the role of the church cannot be ignored at all. You know, the church cannot be opposed to circumcision because even Jesus [*Biblical Christ*] was circumcised (Female, 18 years old).

One discussant was hesitant about the positive influence of the church, and had this to say:

> The church could complicate issues. They always talk of morality and abstinence without seeing that abstinence has 99% failure rate. I know if they do not get the information that circumcision is also for personal hygiene and prevention of other diseases, they may begin to shoot it down just like they are doing with condom use. They [the church leaders] need to be targeted with knowledge [sic] about the general health role of circumcision (Male, 23 years old).

Evidently, discussants were of the view that religious leaders and structures are influential entities in their communities with the power to address major social issues that affect their society, including that of HIV pandemic. They also have much potential in shaping people's attitudes and circumcision seeking behaviors, and should be actively involved as advocates and as channels through which MC messages reach the wider community.

**Influence of local schoolteachers**

Discussants also mentioned that the school system and teachers also had a key influence on youth and could play a role in motivating circumcision seeking behaviour. One of the discussants expressed this perception as follows:

> I also think teachers should also be in a better position to influence youth… they are in greater

> contact to the youth [*sic*]… Most of the time, youth are either school-going or if they are not, they still look up to and interact with their teachers… The relationship between teacher and pupil doesn't seem to end… teacher imparts the knowledge to the students… If they [teachers] are involved, the youth will have a changed opinion because what the teacher tells me is the right thing. Even retired teachers just sitting at home can be involved in talking to the youth who have left school (Male, 17 years old).

Most discussants expressed that teachers provide valuable information to school-going youth about what health issues are important to them. Discussants were of the view that schools were an important venue for discussing and providing health messages relating to sexual and reproductive health, and in changing attitudes and beliefs relating to MC.

## Discussion

In this study, we found that peer groups and established youth forums play a facilitative role in motivating uptake of MC interventions, and thus the successful implementation of MC projects. These results are consistent with previous studies on the role of peer groups and youth organizations in facilitating uptake of HIV preventive interventions (Bianchi et al., 2003; Flood, 2003; Powers & Tiffany, 2006). The results support the social ecological model of health promotion (Glanz et al., 2002; McLeroy et al., 1988). Active involvement of local youth organizations, and other informal networks would significantly function to motivate demand for MC services and facilitate the successful scale-up of MC services.

This study has shown that the role of women in MC scale-up cannot be ignored, and confirm previous findings on the pivotal place of women in HIV prevention through adoption of safe sexual behaviours among men (Richard et al., 1996). Previous studies have shown that women are likely to play a central role in motivating uptake of MC among their male partners (Westercamp & Bailey, 2007). Women are likely to have an indirect influence, especially because of the male perception that women enjoy sex more with circumcised men (Westercamp and Bailey, 2007). These results suggest that women in sexual relationships have an influence on how MC is successfully planned and scaled-up as a public health intervention. Thus, MC projects should make strategic efforts to target and actively involve women in planning and implementation of programs and activities related to MC advocacy. The influence of women in the MC uptake process may however be subdued by oppressive gender and sexual relations. There is need to create gender-interactive forums for community dialogue between men and women, in which they learn more about MC as a HIV preventive measure and a public health intervention.

Furthermore, this study has shown that parents have a major role in decision-making relating to circumcision–seeking behavior. These results are in consonance with findings of previous studies which show the importance of parents and families in the prevention of HIV among adolescents and youth (Romer et al., 1999). Parents are significant role models to their children, support to their developmental trajectories, and direct and shape much of their children's decisions (Henrich et al., 2006). This implies that targeting and involving parents as advocates, deciders and influencers, and motivators of circumcision-seeking behaviour is a priority area for MC scale-up projects in non-circumcising communities.

The role of local community opinion leaders in influencing MC scale-up was another key finding of that study. Previous studies have also found that community involvement and participation in HIV prevention projects begins with the identification and mapping of popular opinion leaders (Romer et al., 1999). Major health promotion theories support the thesis that goodwill and support from political and religious leaders in the intervention community is important in facilitating successful planning and implementation of the health intervention (Glanz et al, 2002; Rollnick et al., 2002). This study finding therefore implies that projects seeking to plan and implement MC interventions must actively seek the involvement and support of community opinion leaders, including religious, political and cultural leaders.

The introduction of MC on a scale that would generate population-level health outcomes requires broad societal acceptance (WHO/UNAIDS, 2008). There is need for enhanced community-wide education and promotional activities that target both proximal and distal factors in the environment that facilitate changes in community-wide beliefs about MC. These promotional activities should not only motivate MC services-seeking behaviours among the target population, but also seek the persuasive support of other interpersonal influences. Furthermore, the efforts towards effective MC promotion, education and information should be intensified through all channels such as radio, drama and peer groups. Local community theatres, local structures like schools and churches, and local

community gatherings (*barazas*) are important avenues through which such promotional messages can be passed or in which community dialogue forums can be facilitated. Community engagement in such dialogue could be done through the establishment of network of peer groups, village educators and volunteers who are respected people in the local communities. However, key audiences for advocacy should be strategically determined so that messages which directly meet the needs and interests of these audiences are developed, tested and implemented.

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